

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER Southern Pointe Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Sherrard Drive Colbert, OK 74733	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216</p> <p>On 04/07/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect a resident's right to be free from neglect.</p> <p>Resident #3 admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type II and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.</p> <p>There was no documentation upon admission of Resident #3 having any skin issues.</p> <p>Resident #3's quarterly assessment, dated 01/13/25, showed the resident required substantial/maximal assistance with all ADL's and had a Braden score of 16, placing them at increased risk of pressure ulcer/pressure injury development. The assessment showed there were no skin concerns.</p> <p>There were no documented skin assessments between 01/26/25 and 02/10/25.</p> <p>A nursing note, dated 02/10/25 at 6:55 p.m., showed Resident #3 was transferred to hospital for altered mental status and slurred speech. There was no documentation of concerns related to the buttock or coccyx.</p> <p>A hospital wound consult note, dated 02/14/25, showed Resident #3 presented upon admission with an unstageable pressure injury to right medial buttock measuring 2.2 cm x 2.0 cm, an improving unstageable pressure injury to right sided coccyx measuring 0.9 cm x 1.4 cm, an unstageable pressure injury to left sided medial coccyx measuring 0.6 cm x 0.9 cm, and an improving open deep tissue injury to midline coccyx measuring 0.6 cm x 0.4 cm.</p> <p>On 04/07/25 at 2:53 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.</p> <p>On 04/07/25 at 3:34 p.m., the administrator was notified of the IJ situation and provided the IJ template</p> <p>On 04/07/25 at 8:57 p.m., an acceptable plan of removal was approved by the Oklahoma Stated Department of Health. The plan of removal, read in part,</p> <p>April 7, 2025</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Southern Pointe Living Center</p> <p>Plan of Removal for Neglect</p> <p>Completion Date 4-8-25 4:00 p.m.</p> <p>All staff will be educated on the Abuse and Neglect Policy & Procedures. A sign in sheet will be utilized for employees that are currently working in the facility. Any remaining staff that aren't at the facility will be called and educated over the telephone. Employee name and time of call will be documented.</p> <p>Currently in progress: All residents will be assessed head to toe for skin issues. Skin assessments will be completed for each resident. Wound assessments will be completed for each skin area identified. A SBAR and incident report will be completed for any identified skin areas. Weekly skin assessments will be completed for each resident. Weekly wound assessments will be completed until each skin area is resolved. The physician will be notified for any resident having skin areas and treatment orders will be obtained. The resident/responsible party will be notified of any new orders received from the physician. The dietary manager will be notified of any pressure ulcers identified. Skin care plans will be updated if applicable.</p> <p>The IJ was lifted on 04/08/25 at 5:53 p.m., when all components of the plan of removal had been verified as completed. Staff education related to abuse and neglect, resident skin assessments, and physician notification regarding resident skin issues were reviewed. The deficient practice remained at an isolated level with the potential for more than minimal harm.</p> <p>Based on record review and interview, the facility failed to ensure a resident at risk for pressure ulcers was not neglected by not being assessed and monitored to prevent pressure ulcers for 1 (#3) of 3 residents sampled for pressure ulcers/pressure injury.</p> <p>The administrator identified 41 residents resided in the facility.</p> <p>Findings:</p> <p>A policy titled Abuse-Reportable Events, revised 08/2019, read in part, Neglect .The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .Deprivation of Goods and Services .when staff has the knowledge and ability to provide care and services, but choose not to do it or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident .It is the responsibility of every employee to report immediately anything that could adversely affect the health and welfare of any resident.</p> <p>A policy titled Skin Integrity Monitoring System, revised on 04/03/21, read in part, It is the policy of this facility that .A system will be in place to assure that all residents will be assessed and monitored for any type of skin breakdown .A system will be in place to assure that all residents will be assessed, and preventative measures will be in place to prevent the development of pressure ulcers .A system will be in place to assure any type of skin conditions that do not constitute pressure ulcers will be monitored for any type of complications .CNA's will report any changes in skin integrity to the charge nurse using the daily CNA bath sheet.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #3 admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type II and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.</p> <p>Resident #3's admission assessment, dated 07/13/23, showed Resident #3 had no skin issues and no pressure ulcers upon admission, and they were at risk for pressure ulcers.</p> <p>Resident #3's quarterly assessment, dated 01/13/25, showed Resident #3 required substantial/maximal assistance from staff with their ADL's. The assessment showed there were no skin issues.</p> <p>There was no documentation Resident #3 had weekly skin assessments conducted between 01/26/25 through 02/10/25.</p> <p>There was no documentation Resident #3 received treatment for pressure ulcers/pressure injuries.</p> <p>A nursing note, dated 02/10/25 at 6:55 p.m., showed Resident #3 was transferred to hospital for altered mental status and slurred speech. There was no documentation of concerns related to the buttock or coccyx.</p> <p>A hospital wound consult note, dated 02/14/25, showed Resident #3 presented upon admission with an unstageable pressure injury to right medial buttock measuring 2.2 cm x 2.0 cm, an improving unstageable pressure injury to right sided coccyx measuring 0.9 cm x 1.4 cm, an unstageable pressure injury to left sided medial coccyx measuring 0.6 cm x 0.9 cm, and an improving open deep tissue injury to midline coccyx measuring 0.6 cm x 0.4 cm.</p> <p>On 04/03/25 at 10:43 a.m., regional nurse consultant stated there was no documentation of wounds prior to Resident #3 readmitting on 02/20/25 at 4:12 p.m. to the facility.</p> <p>On 04/03/25 at 11:43 a.m., regional nurse consultant stated the expectation of staff was to look at the residents' skin and document any findings on the skin sheet.</p> <p>On 04/03/25 at 11:45 a.m., regional nurse consultant stated none of the CNAs documentation showed Resident #3 had skin issues.</p> <p>On 04/03/25 at 4:50 p.m., regional nurse consultant stated no inservices had been conducted to address the lack of skin assessments.</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216</p> <p>On 04/07/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure a resident at risk for pressure ulcers was assessed and monitored to prevent pressure ulcers.</p> <p>Resident #3 admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type II and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.</p> <p>An admission assessment, dated 07/13/24, showed no skin concerns.</p> <p>Resident #3's quarterly assessment, dated 01/13/25, showed the resident required substantial/maximal assistance with all ADL's and had a Braden score of 16, placing them at increased risk of pressure ulcer/pressure injury development. The assessment showed no skin concerns.</p> <p>There were no documented skin assessments between 01/26/25 and 02/10/25.</p> <p>A nursing note, dated 02/10/25 at 6:55 p.m., showed Resident #3 was transferred to hospital for altered mental status and slurred speech. There was no documentation of concerns related to the buttock or coccyx.</p> <p>A hospital wound consult note, dated 02/14/25, showed Resident #3 presented upon admission with an unstageable pressure injury to right medial buttock measuring 2.2 cm x 2.0 cm, an improving unstageable pressure injury to right sided coccyx measuring 0.9 cm x 1.4 cm, an unstageable pressure injury to left sided medial coccyx measuring 0.6 cm x 0.9 cm, and an improving open deep tissue injury to midline coccyx measuring 0.6 cm x 0.4 cm.</p> <p>On 04/07/25 at 2:53 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.</p> <p>On 04/07/25 at 3:34 p.m., the administrator was notified of the IJ situation and provided the IJ template.</p> <p>On 04/07/25 at 8:57 p.m., an acceptable plan of removal was approved by the Oklahoma Stated Department of Health. The plan of removal, read in part,</p> <p>April 7, 2025</p> <p>Southern Pointe Living Center</p> <p>Plan of Removal for Pressure Ulcers</p> <p>Completion Date 4-8-25 4:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>All staff will be educated on the Skin Policy and Procedures by the Regional Nurse, [name withheld, and/or [name withheld], Regional Director. A sign in sheet will be utilized for staff that are currently in the facility. Any remaining staff will be called to the facility for education; or educated over the telephone. Employee names and time of call will be documented.</p> <p>Currently in progress: All residents will be assessed head to toe for skin issues. Skin assessments will be completed for each resident. Wound assessments will be completed for each skin area identified. A SBAR and incident report will be completed for any identified skin areas. Weekly skin assessments will be completed for each resident. Weekly wound assessments will be completed until each skin area is resolved. The physician will be notified for any resident having skin areas and treatment orders will be obtained. The resident/responsible party will be notified of any new orders received from the physician. The dietary manager will be notified of any pressure ulcers identified. Skin care plans will be updated if applicable.</p> <p>The IJ was lifted on 04/08/25 at 5:53 p.m., when all components of the plan of removal had been verified as completed. Staff education related to skin policy and procedures, resident skin assessments, and physician notification regarding resident skin issues were reviewed. The deficient practice remained at an isolated level with the potential for more than minimal harm.</p> <p>Based on record review and interview, the facility failed to ensure a resident at risk for pressure ulcers was assessed and monitored to prevent pressure ulcers for 1 (#3) of 3 residents sampled for pressure ulcers/pressure injury.</p> <p>The regional nurse consult identified three residents residing in the facility had pressure ulcers.</p> <p>Findings:</p> <p>A policy titled Skin Integrity Monitoring System, revised 04/03/21, read in part, It is the policy of this facility that: .A system will be in place to assure that all residents will be assessed and monitored for any type of skin breakdown .A system will be in place to assure that all residents will be assessed, and preventative measures will be in place to prevent the development of pressure ulcers .A system will be in place to assure any type of skin conditions that do not constitute pressure ulcers will be monitored for any type of complications .CNA's will report any changes in skin integrity to the charge nurse using the daily CNA bath sheet.</p> <p>Resident #3 admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type II and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.</p> <p>Resident #3's admission assessment, dated 07/13/24, showed Resident #3 had no pressure ulcers upon admission and they were at risk for pressure ulcers.</p> <p>Resident #3's quarterly assessment, dated 01/13/25, showed the resident required substantial/maximal assistance with all ADL's and had a Braden score of 16, placing them at increased risk of pressure ulcer/pressure injury development. The assessment showed no skin issues.</p> <p>There were no documented skin assessments between 01/26/25 and 02/10/25.</p> <p>(continued on next page)</p>		

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